TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
NORTHWEST SURGERY CENTER RED OAK

MFDR Tracking Number
M4-17-2245-01

MFDR Date Received
March 27, 2017

Respondent Name
OLD REPUBLIC INSURANCE CO

Carrier's Austin Representative
Box Number 44

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The authorization was for hardware removal, which is included in CPT code 28322, as well as percutaneous reduction of 5th MT of the left foot. Once [injured employee] was under general anesthesia, the physician removed the screws and plate and he noted: '...there was evidence of a fibrous malunion at the left fifth metatarsal base, which was only partial in nature and not across the entire base.' This was repaired for the patient's successful recovery. It many have contributed to the patient's pain as well. It is for these reasons that I am requesting Sedgwick to reconsider this claim and reimburse Northwest Surgery Center accordingly."

Amount in Dispute: $6,009.90

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Respondent correctly denied payment on this matter as preauthorization was not obtained for the surgery performed. Preauthorization was initially denied for the requested surgical procedure. The provider and Dr. Trotter (carrier's peer review doctor) then had a peer-to-peer conversation in which they agreed that only the hardware removal, post splint and fluoroscopy were medically necessary. The percutaneous reduction was agreed to not be medically necessary. The provider then performed the reduction during the January 31, 2017 surgical procedure. This is noted in the operative report. The provider then billed for this procedure as well as the other procedures under one billing line. As the provider's bill included a procedure which was agreed to be not medically necessary, payment was denied."

Response Submitted by: White, Espey PLLC

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Service(s)	Amount In Dispute	Amount Due
January 31, 2017	28322	$6,009.90	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all-applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes
2. 28 Texas Administrative Code §134.600 sets out the guidelines for preauthorization, concurrent review, and voluntary certification of healthcare.
3. 28 Texas Administrative Code §134.203 sets out the sets out the fee guidelines for the reimbursement of workers' compensation professional medical services provided on or after March 1, 2008.

4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 197 – Payment denied/reduced for absence of precertification/authorization.
   - 247 – A payment or denial has already been recommended for this service

Issues

1. Did the requestor obtain preauthorization for the disputed services?
2. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §134.203 (b) states in pertinent part, "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules ."

   The requestor seeks reimbursement for CPT Code 28322 defined by the AMA CPT Code Book as "Repair, nonunion or malunion; metatarsal, with or without bone graft (includes obtaining graft)."

   Review of the preauthorization letter issued by Sedgwick, dated January 10, 2017, states in pertinent part, "The AP called back on 01/09/16 at 12:40 pm CDT. He indicated that the fracture healed and that the hardware is painfully symptomatic. He indicates that the current requests should only include hardware removal, postop splint and fluoroscopy. These ARE medically reasonable and necessary at this time. A percutaneous reduction is not reasonable or necessary."

   28 Texas Administrative Code §134.600(c) (1) (B) states in pertinent part, "(c) The insurance carrier is liable for all reasonable and necessary medical costs relating to the health care: (1) listed in subsection (p) or (q) of this section only when the following situations occur... (B) preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care..."

   The Division finds that the requestor did not obtain preauthorization for the disputed CPT Code 28322. As a result, the insurance carrier is not liable for reimbursement for the disputed service.

2. Review of the submitted documentation finds that the requestor is not entitled to reimbursement for CPT Code 28322 rendered on January 31, 2017 as preauthorization was required and not obtained. No reimbursement is recommended for this service.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	May 4, 2017 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.